Physicians Task Force Meeting
May 19, 2010

Dr. Robert Moon called to order the Physicians Task Force Meeting at 1:30 PM in the Boardroom.

Members Present: Dr. John Jernigan, Dr. Malcolm Brown, Dr. Eduardo Gonzalez, Dr. Robert Smith, Dr. Larry Finn, Dr. Maurice Fitz-Gerald, Dr. Tom Miller, Dr. Marsha Raulerson, Dr. Billy Sellers.

Medicaid Staff Present: Dr. Mary McIntyre, Gretel Felton, Jerri Jackson, Mary Ann Fannin, Kathy Hall, Charlane Griffith, Carolyn Thompson, Kelli Littlejohn, PharmD, Paige Clark, Mattie Jackson, Colinder Chappelle and Audrey Middleton.

Others present: Cyndi Crockett, HP

Webinar/Teleconference Dr. Sandral Hullett, Dr. Vinit Mahesh, Cary Kuhlmann and Dr. Steve Baldwin, Dr. Fitzgerald.

Opening Remarks - Dr. Moon
Due to passage of healthcare reform Patient Protection and Accountable Care Act (PPACA), the Agency anticipates a growth in the Medicaid rolls between 200 and 400 thousand recipients by 2014 primarily adult patients and many with unmet needs. The Agency has begun working on changes associated with the legislation.

The minutes from the last meeting were accepted with no changes.

Legislative Update - Audrey Middleton:
The 2010 legislative session ended April 22 with passage of the General Fund budget of $1.6 billion dollars. Medicaid was appropriated $345 million dollars toward the entire Medicaid 2011 budget of $5.2 billion dollars and an additional appropriation of $35 million dollars from the Children's Trust Fund. A supplemental appropriation passed giving the Agency $22 million dollars for this fiscal year. The Nursing Home Privilege Tax will generate a net gain of $25 million dollars. Some changes are expected next year in the Legislature. There will be at least 10 new Representatives and 7 new Senators. Legislative Affairs staff will continue to educate them about the impact Medicaid has on the state.

Health Systems/Medicaid Home Redesign - Dr. Moon:
A study has been completed of several other state programs specifically Georgia, Tennessee, Texas, South Carolina and North Carolina (among others). Medicaid plans to release an RFI in the next few weeks, hopefully by June 1, requesting input on the payment and delivery system suggestions for Alabama Medicaid.

As part of the medical home redesign, we are studying care networks like those in North Carolina in hopes of building upon their successes. We are involving a variety of stakeholders in developing care networks to help providers manage care for their patients. We have involved other state agencies, associations, and providers. The workgroup has identified Community Care of North Carolina as a good model for us to evaluate for Alabama.

Dr. Steve Baldwin suggested that we look at it from the patient/provider angle more; especially considering that the provider capacity will become more stressed as Medicaid increases the number of eligibles. People are concerned that access to care will diminish as provider overhead increases.

The complexity of patients will continue to increase and the medical home needs to include that complexity in planning.

Dr. Smith expressed concern that if there's going to be this influx of eligibles, and providers are already stretched, who is looking at expanding the pool of physicians to take on the responsibility. Providers in Birmingham especially are stretched; and if another 300,000 are added, the quality of care will diminish as well because there are not enough providers.

Dr. Mary McIntyre stated that there are several grants and other funding for workforce development, but it will take years to address the provider workforce issue.

Dr. Vinit Mahesh said patient accountability is a problem, 15% to 20% no shows affect staff time and overhead cost and other patients needing to get in to see the doctor. Patient accountability must be built into any structure or medical home concept in order to maximize resources. Recipients are not showing for their scheduled appointments and ideas are needed on how to encourage recipients to keep their appointments without punishing the children because parents are disorganized or dysfunctional. Dr. Moon indicated that this is a common problem for many states and no state seems to have developed a consistently successful intervention. In the care network model, care coordinators will assist in modifying recipient behavior regarding no shows, but even that will not be a magic bullet.

Dr. Smith stated that if this is not dealt with nationally, it will not change. Providers are not permitted to punish or hold the parents accountable; therefore, unless Medicaid from state to state has some method to hold parents accountable, it will not work. In the Atlanta area, they have an effective method that's not real expensive where the providers call the Sherriff department who goes to the parent's home. Alabama needs to look at this method or come up with a solution.

Process Issues – Task Force Members:

Dr. Baldwin asked about patient reassignment to different primary care physicians and the original physician has to obtain a referral from the assigned physician. He was concerned about why this continues to be a problem. Paige Clark indicated that there are several different reasons for patient reassignment. For example, a provider may have their panel on hold, a patient loses eligibility, and when they become eligible again, the provider's panel is closed. The Patient 1st Roster (which is downloadable from the web portal) contains coding to indicate why a patient was added or terminated. The provider roster has a legend that specifically identifies the two-letter codes on the roster. Statistics are not kept on reassignments. Each provider has flexibility as to how many recipients they will enroll and to place their panel on hold, but can authorize Medicaid to go above the panel hold. If a recipient falls off a physician panel and is then reassigned, they are notified who the new provider is and given 35 to 45 days before the assignment becomes effective to change to a provider of their choice and call the provider personally requesting to be added, changed, or switched back. The system does tell why changes were made to the panel. Dr. Baldwin suggested Medicaid extend coverage to the recipient before assigning to a primary care physician and keep them in the system while Medicaid make the change in order to keep patients from falling off the panels, thus and the nightmare of patients showing up to the wrong primary care doctor and the doctor has to see them. Ms. Clark stated that recipients usually will not take action until they are prompted to do so when the child or adult gets sick, therefore, even with the eligibility flexibility, it may not affect their behavior, but the Agency will review the option.

Dr. Smith says this places an extra burden on the physician to figure out what went wrong. Many patients will go on and off Medicaid and do not know about the reassignment. When providers

have a closed panel, they are often unaware a recipient has lost eligibility and fallen off the panel, but they continue to have the recipient listed on the panel, this is a problem. Ms. Clark explained the reassignment and patient override process.

HIE/HIT - Charlane Griffith:

In February the Agency received a $10.5 million dollar grant to build a statewide HIE. Our vision is one patient, one record in building that exchange. The goal is to design a system that will capture all the patients, all the providers and all the payers in one system. In January, the Governor appointed a 23-member commission made up of various state and local agencies, commercial insurance market representatives, and a representation of all types of providers throughout the state in conjunction with ONC and CMS. There are six workgroups: Governance, Finance, Legal and Policy, Business Technical, Technical Operations, and Communications/Marketing. A draft of the Strategic Plan was submitted to ONC last week and staff is in the process of writing the Operational Plan. Both plans will need to be submitted and approved before funding can be received. Other monies/grants are coming into the state that will support this effort.

This is a four-year funding cycle (federal/state match rate) beginning in September 30, 2010, ***(100% year 1 with no matching requirements, 90/10 year 2; 70/30 year 3; 30/70 year 4).*** Additional funding will be available to providers. The Commission is in the process of selecting a logo. Alabama is working very closely with Border States in the Southeast region as well. Phase I of the HIE will have a master patient index, provider directory, record locator service, e-prescribing, lab orders and entry, administrative data, medication history, and build a larger house so more data fields can be collected. Phase II will add data elements and provide an easier way for provider usage, especially rural providers. Phase III will connect to the state lab and gather quality reporting data and track utilization. HIE will be web based. Providers can choose from the Medicaid timeline when to come into the system, year 1, etc. Providers will be registered and there will be a set of quality measures for them to uphold that Medicaid will validate.

The Meaningful Use final rule is due by June 23. We are in the process of hiring a state HIT Coordinator, hopefully by June 15. Margaret McKenzie, Governor's office staff, currently holds the position. Current plans are to start enrolling providers for Meaningful Use payments by July 1 and by October 1 start capturing Meaningful Use requirements. A go live date has been set for March 2011 for Beta testing and the date for being fully operational is July 1, 2011.

Eligibility - Gretel Felton:

In 2014, Medicaid will need to put several new people on the eligibility rolls, but in the interim, we are trying to streamline our enrollment as much as possible. There are a few initiatives to work toward that end. Alabama has already done a very good job of streamlining the application process. In December, the Agency was awarded a $39.1 million dollar bonus award grant from CMS for putting on Medicaid eligible children. The total for the US was $72 million dollars, therefore, Alabama received over 53 percent. Alabama is very proud of the efforts we have made. To receive that bonus amount, Medicaid had to meet five out of eight eligibility streamlining efforts: 1) joint application with ALL Kids, 2) pre-populated renewal, 3) 12-month continuous eligibility, 3) remove the asset test, 4) do not have a face-to-face interview requirement. Also, we were the only state that had a second tier of eligible children.

Some of the newer streamlining efforts include a grant for technical assistance and support from the RWJ foundation and the National Academy of State Health Policy. ALL Kids is the lead agency. A project team traveled to Louisiana to review their program, and was very impressed. Therefore, one of the newest efforts we are looking forward to implementing in our eligibility area is telephone

renewal, simplified renewals, online renewals and a continuation of Express Lane Eligibility (ELE). Additionally, Medicaid plans to use UAB as a contractor to conduct focus groups with recipients in Jefferson and Montgomery counties and surrounding areas. They will interview the following groups by using a satisfaction survey:

- disenrolled Medicaid recipients that did not attempt to renew to determine why,
- disenrolled Medicaid recipients that waited until coverage lapsed to come back on, and
- enrolled Medicaid recipients who used the web application verses the paper application.

This will give the Agency information to determine what we will do in the future. Plans are to push the web application as much as possible. Also, staff hopes to begin working with MyAlabama.gov, formally, Camellia to develop an applications to apply for Medicaid, ALL Kids, food stamps or now referred to as SNAP, or unemployment compensation online at "one web portal." Eventually recipients would be able to apply through the web portal for additional social services programs and to apply for hunting, fishing and driver license, etc.

Another program we are looking at is Passive Renewals for low-risk recipients. For example, we do not count the income of grandparents who are caretakers of the children where only the children's income is counted and there is a low risk that their income will change. Staff will make the determination of who is low risk and automatically renew coverage without sending a written notice. ELE is continuing. It has helped the renewal process in that staff will no longer request income verification from parents, but will use the SNAP application to award Medicaid eligibility to the child based on their income findings. This began in October and has been going very well. We have re-determined over 4,000 children. Also, beginning April 1, 2010, this process has begun for all new applicants. CHIPPRA legislation allows us to do a data match with SSA instead of paper Citizenship verification from the recipient, so the Agency began using this process in January 2010. Results are that 94.5% have proven to be citizens, 1% not citizens, 4.5% citizenship is unknown, which could be the result of inputting the wrong SSN ~~which~~ and can be easily corrected. Statistics are very good, but with CHIPPRA legislation, even if there is no match, ~~they~~ both children and adults would still be eligible for Medicaid because they meet all other requirements. They have 90 days to correct the information or be terminated. This has helped Medicaid get applicants on the roll almost immediately. In responding to a question, Ms. Felton stated this new match applied after January 1, 2010. ALL Kids is also using this process.

Dr. Raulerson asked how to handle applicants who have never applied or eligibility has lapsed? Ms. Felton suggested they be referred to the Medicaid worker because if the lapse has been recent, they can be placed back on the roll. Unfortunately, the lapse in many applicants' coverage is due to a change of addresses. Some of these new efforts will hopefully prevent this in the future, especially the online applications. Dr. Raulerson stated that online applications may be more of a problem in rural areas. Ms. Felton suggested that a supervisor in the area can review the problem with lapses in coverage. Many of the workers will be moved from their isolated outstations (where they answer phone calls, process mail and filing, respond to emails, work cases not in their caseloads) into district offices so they will have more clerical support and be able to process applications and if they are out of the office they will have assistance with their caseloads. The Mobile District office is the next area to make this transition.
Dr. Raulerson asked about tracking the unborn's mother. It was suggested that the Maternity waiver program could be the mechanism to track the mothers. Dr. Moon stated that part of what the care coordinator's responsibility is to meet with the mom at the hospital after delivery. If this is not being done, the Agency will review the situation. Ms. Felton said a form is on the website that providers who do not have a Medicaid number for the baby, the Agency can look up and give them

the number. Dr. Raulerson also brought up the issue of mothers on SSI. Ms. Felton suggested that they may need to apply, but sometimes after one year if they are not on Medicaid they are put on with the other children, but applications are sent when they are about to deliver.

Medical Services - Kathy Hall:
The Commissioner's budget recommendations to the legislature included a few program changes to Psychologist reimbursement rates. Meetings are ongoing to come up with some alternatives to changing the reimbursement. Some initiatives being considered include billing in smaller time increments, using modifiers to bill for supervision of services and requiring better documentation of services provided. Policy changes are forthcoming.

Ms. Hall also informed the group that Medicaid staff began attending Pediatric council meetings sponsored by the Alabama Chapter of the American Academy of Pediatrics about two years ago. This has given the Agency an opportunity to come together with other payers in the state and the academy to address issues. The next meeting is early June.

Mary Ann Fannin is new to the Maternity division as the Maternity director, but unfortunately she will be retiring soon.

Maternity Program – Mary Ann Fannin:
Smoking Cessation products are now covered for the maternity population. A provider alert has been sent out. So far there are no patients filling prescriptions for smoking cessation products, but plans are being made about how we can get information out about the service. A comment was made that the coordinators are only required to conduct two visits with the recipient. Dr. Moon stated that the visit requirements were changed to better use care coordinators time. They are not limited to two visits, but we only require two visits. Quality measures were built into the incentive plan as well.

The Agency has entered into an agreement with ADMH January 1st to cover screening for alcohol and substance abuse, brief intervention and referral for treatment services (SBIRT) for Medicaid eligible maternity patients. There is an online tutorial developed by the ADMH that after providers complete the tutorial, we can enroll them as a provider for this service and they can refer the client for treatment. Currently, there are 11 providers enrolled.

Plan 1st has moved under the Maternity Care program effective April 1. We increased reimbursement for the Marina IUD effective March 1 from $468 to $703.

In response to a question about post-partum depression, Dr. Moon said psychosocial screening is part of the care coordination system. Dr. McIntyre said that this is a national issue too. They are looking at it as part of the new pediatric quality measures. Another question is whether or not these mothers are referred to ADMH. Dr. Raulerson said they try and get them into emergency visits with the local mental health person who is on call that day or sometimes contact another family member. Access to mental health usually takes a month or two and the baby is at risk. Dr. Raulerson stated that sometimes she writes a prescription. Dr. Moon stated that according to ADMH these clients have the highest priority, but he would take the access issue back to them.

Medical Services - Jerri Jackson:
Telemedicine has been implemented in the Physician program April 1, 2010. It is open to psychiatrists and dermatologists. Dr. Moon said a key feature of this policy is, if the situation meets all of the other criteria in the policy, a telemedicine visit will be accepted as a face to face in these

two areas of medicine to receive payment. If you refer a patient to a psychiatrist and they live more than 50 miles away from the psychiatrist they are eligible to have a telemedicine visit.. There are several sources of grants available for the equipment. There are providers using the service. Dr. Raulerson has been using it for several years. Dr. Steven Baldwin asked when the next expansion in telemedicine coverage is and Dr. Moon indicated that a date has not been set.

Utilization Review Policy is being implemented in the Hospital Program effective July 1. Effective for admissions on or after July 1, 2010, Medicaid will require hospitals to report dates that do not meet InterQual® Adult and Pediatric Medical Criteria and Alabama Medicaid Local Policy on the UB-04 claim form. Hospitals will continue to use the Alabama Medicaid SI/IS criteria for admissions. This gives us an opportunity to get the information stating what the impact would be in determining how many people that meet our criteria that would have non-covered days if we went to the InterQual criteria. The providers will not see any changes. The hospital will have to do extra work. Education and training has been held throughout the state. A PowerPoint is on the website.

Adverse Events: Effective July 1, 2010, Medicaid will require hospitals to report Adverse Events. Included under this policy are Serious Preventable Events, Hospital-Acquired Conditions and Present on Admission Indicators and Billing. Dr. McIntyre indicated that the Agency must implement a policy to cover these events also called "Never Events." The federal government, through healthcare reform, will not pay Medicaid programs for health care acquired conditions effective July 1, 2011. The rule requires CMS to consider States' existing policies in the development of the final regulations. There will be a mechanism to capture this data to come up with a national policy as it relates to what is already in place with Medicare. The Agency is following Blue Cross's criteria that hospitals are already familiar with which is consistent with the Medicare policy.

The Radiology Program has a new program Manager, Carolyn Thompson. A reminder has been sent to providers that they have 30 days to change the coding.

Pharmacy – Dr. Kelli Littlejohn

The Pharmacy Associations have been working with pharmacies and the Agency on reimbursement modification which passed in the FY2011 budget. Research has begun on Phase III of the reimbursement modification to include pharmacies and pharmacists into the Medical Neighborhood concept. A meeting is planned in June with the associations to begin discussions and bring in the pharmacies to meet with the Medical Home workgroup as well. A State Plan Amendment and Administrative Code change has been submitted on Phases I&II, and copies of most everything is located on the Agency website.

Dr. Littlejohn continued the pharmacy update outlining various pharmacy changes related to the PPACA (Affordable Care Act). There are several retroactive changes to the federal rebate program that may affect the preferred drug list. States are collaboratively discussing with CMS. Effective January 2101, the Medicaid pharmacy program will become a "benchmark benefit", which means pharmacy coverage for adults is no longer optional. Also, Kelli reviewed the recent interim rule change on DEA e-prescribing for controlled substances to be implemented June 1.

One of the Task Force members mentioned that he had a conversation with a specialty pharmacy, who had some concerns regarding the new reimbursement modification; his discussion with this particular pharmacist centered around the Cost of Dispensing for specialty pharmacies. The physician asked if the Agency could look at a "tiered dispensing fee", carving out certain specialty pharmacies who conducted additional clinical services. Dr. Littlejohn recognized that she had the

same discussion with that particular provider, and while that particular provider did not participate in the recent Cost of Dispensing survey, due to the concerns brought forth by this and other specialty providers, the Commissioner had encouraged beginning open meetings, communication, research, and development of Phase III of the reimbursement modification, reimbursement of professional services. As mentioned earlier in the pharmacy update, a meeting is scheduled in June for pharmacy associations and providers to begin work on this project. Providers have been encouraged to submit comments and ideas to the Agency that could result in "shared savings", much like the current Patient 1st model. As far as the "tiered dispensing fee", any change to the dispensing fee must be approved by CMS, which must be supported by a statistically valid survey. The current survey report is located on the Agency website, where you can read that the primary variable affecting a pharmacy's cost of dispensing is prescription volume.

In response to a question about determining drug coverage on certain drugs, Dr. Littlejohn gave the Pharmacy Division phone number and mentioned that a drug look up online proposal is with the Commissioner that should be included in the new MMIS that will allow an online drug look up by typing in the name of the drug and receiving the necessary information related to the drug such as covered NDCs, PAs, MAX units, etc.

Healthcare Quality Measures - Dr. Mary McIntyre:
Information is on the website regarding Alabama Healthcare Improvement and Quality Alliance (additional information in the packets). This is a venue for stakeholders to collaborate on healthcare quality. A meeting is scheduled tomorrow and information from prior meetings is on the Medicaid website. Because of the CHIPRA legislation and the Core Measure Set, QI staff has identified 22-24 quality measures. QI/S Staff along with Statistical Support are trying to determine how many measures can be retrieved from the administrative claims data. Healthcare reform has a requirement for an Adult Quality Measures set. It is not certain how many measures will be identified through this process. Also ARRA/EHR Meaningful Use has a clinical performance measure requirement. It is not certain what the total number of measures will be. The Agency's goal is to make certain to have a formal strategy or framework in hopes the federal government will look at state strategies in the development of the National Quality Strategy.

Cary Kuhlmann asked about a form physician uses to apply to Blue Cross and Medicaid. He received a call from a physician's office manager that Medicaid is no longer accepting the application and that the physician would need to fill out a separate Medicaid application. Kathy Hall stated that no changes have been made to enrollment procedures, but would review the issue.

After some discussion, the Task Force agreed to meet again August 19, 2010.

Robert Moon, MD, Medical Director

Colinder Chappelle, Recorder